



## **IRO REVIEWER REPORT – WC**

**DATE OF REVIEW:** 03/28/16

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right S1 Transforaminal Epidural Steroid Injection

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Physical Medicine and Rehabilitation and Pain Medicine

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute:**

- Right S1 Transforaminal Epidural Steroid Injection - Upheld

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant injured her back in XXXX and has had chronic low pain since. Historical records are limited, but there is no indication of prior surgery. There is reference to prior injection. Current medications include Neurontin and Norco. A right S1 transforaminal ESI has recently been recommended.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

It is my medical opinion, based upon review of the available records, that the right S1 transforaminal epidural steroid injection is not reasonable or necessary medically. The claimant does not meet the criteria for use of epidural steroid injection, which is indicated

for use in acute radiculopathy when clinical signs and symptoms are present and corroborated by imaging studies. The claimant has an injury dating back almost xx xxxxx. She has intermittent flares of symptoms with vague, nonspecific radicular complaints not corroborated by the most recent imaging studies. As such, the Official Disability Guidelines criteria for use of this modality are not met in this case.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**